Statement of Buford L. Rolin
Chairman
National Indian Health Board
on
S. 299, a bill to elevate the Director of the Indian Health Service (IHS)
to
Assistant Secretary for Indian Health
within the Department of Health and Human Services,
and
S. 406, a bill that would allow tribes to bill directly for Medicaid and Medicare.
August 4, 1999

Chairman Ben Nighthorse Campbell, and distinguished members of the United States Senate Committee on Indian Affairs, I am honored to offer testimony on behalf of the National Indian Health Board (NIHB) in support of S. 299, a bill to elevate the Director of the Indian Health Service (IHS) to Assistant Secretary for Indian Health within the Department of Health and Human Services and S. 406, a bill to make permanent and expand the Tribal Medicare/Medicaid direct billing project.

The NIHB serves all 558 Tribal Governments in advocating for the improvement of health care delivery. Our Board Members represent each of the twelve Indian Health Service Areas, and are generally elected at-large by Tribal Governmental officials within their respective regional Areas. The NIHB has a duty to represent the sovereign right of all Tribal Governments to promote the highest levels of health for American Indians and Alaska Natives, and to advise the federal government in the development of responsible health policy.

The National Indian Health Board strongly supports enactment of S. 299 and S. 406. We believe through enactment of S. 299, the Government-to-Government relationship between the United States and each Tribal Government will be better fulfilled if the Director of the IHS is elevated to a position of higher authority thereby promoting greater consultation on matters related to Indian health within the federal government. With enactment of S. 406, the NIHB is convinced that permanent establishment of direct Federal billing under Medicaid and Medicare will reduce the bureaucracy involved between agencies and will enhance third party collections for all Tribes. Each of these two health bills will significantly improve the quality and quantity of health care services at the grassroots, tribal level.

S. 299, a bill to elevate the Director of the IHS to Assistant Secretary for Indian Health.

Mr. Chairman, I am here today to impress upon the Senate Committee on Indian Affairs, as to why they should pass S. 299 and why the Administration should move to enact this important legislation into public law.

Before, I proceed, I want to express our sincere appreciation to this Committee for its long-standing support for legislation to elevate the position of the IHS Director, and to thank the cosponsors of S. 299, Senators Conrad, Inouye, and McCain. We especially want to thank Senator John McCain for his willingness to persevere on this most important legislative proposal.

The National Indian Health Board upholds the right of Tribal Governments in their legal position regarding the United States Government to live up to its Treaty obligations and their desire to have comprehensive health care provided to all American Indian and Alaska Native citizens, at a level which should be comparable to the care provided to any other American.

Despite new technological advances, Indian people are suffering and dying premature deaths, due in large part to under funding of the Indian Health Service. While there is little doubt that the overall health status of American Indians and Alaska Natives has substantially improved in the second half of the 20th century it is also unfortunate, as we prepare to enter a new millennium, that new epidemiological data on the American Indian and Alaska Native population detect increased areas of concern. Throughout Indian Country there is a rise in chronic diseases, especially diabetes; there is the persistence of infectious diseases, and there is also a high prevalence of multiple "social pathologies" such as violence, unintentional injuries, and the ill effects of alcohol and drug abuse. Under an Assistant Secretary for Indian Health, American Indians and Alaska Natives will be provided with representation which will include functions specific to ensuring comparable health care by eliminating health care disparities within the Department of Health and Human Services.

In America, as in no other industrial nation, the health of an individual is linked to their wealth. Access to health care is only limited to those who have the means to pay for it. For American Indians and Alaska Natives, who are three times more likely to live in poverty than people of all other races, private health insurance is generally unavailable. This places American Indians and Alaska Natives on the lowest rung of the insurance ladder, in a nation with greater gaps in the health care safety net than all other industrial nations. The Indian Health Service and Tribal Health Systems narrow this gap. In FY 1998, the IHS made health services available to 1.46 million American Indians and Alaska Natives. Programs funded by the IHS provide a range of health delivery systems, including hospitals, outreach programs, referral stations and comprehensive outpatient health clinics.

Because the IHS is not an entitlement program but one dependent on annual appropriations, IHS and Tribal health beneficiaries bear the burden of inadequate funding. Shortfalls limit access to health services and restrict the types of health services they may obtain. When Congress enacts legislation to balance the national budget, the IHS is not spared. Without necessary cost of living adjustments and an effort to lift the spending caps, we predict that health services will be severely affected. This year, thousands of people may be denied hospital admission, nearly half a million outpatient visits may be reduced, dental services may be cut, mental health and social services could be decreased, public health nursing home visits may not be performed and CHR visits may be severely impacted.

A concern which has been raised repeatedly by tribal leadership this past year is the tremendous financial blow on an already inadequately funded IHS as compared to other programs within the Department of Health and Human Services (DHHS) who did not suffer similar consequences. Clearly Indian Health Service and tribal programs are losing further ground this year, and the people who will suffer are Indian people back in our tribal communities.

One of the key reasons for limited funding is the inability of the Indian Health Service to get the attention and support within the Department and the Office of Management and Budget. In the view of Indian Country this translates into lack of respect.

With enactment of S 299, the Assistant Secretary for Indian Health will have access to other agencies within the DHHS system to help shape policies and initiatives that will make the Indian Health Service a stronger ally for Indian country.

Although tribal leadership was pleased with the Departments effort this past year to implement the Tribal "Consultation" policy, legislative mandates, and Executive Orders issued by the President, there continues to be unfinished business regarding the elevation of the Director of the Indian Health Service to the position of Assistant Secretary of Indian Health. Since IHS still bears much of the burden of providing health services to American Indians and Alaska Natives it makes no sense to us to not have the key player at the table when issues pertinent to tribal populations are being determined. In review of the Departments implementation effort a more comprehensive approach in the consultation process could have been accomplished through the position of an Assistant Secretary for Indian Health.

With the elevation of the IHS Director to the position of Assistant Secretary for Indian Health, the IHS will be able to provide a direct line of communication to Secretary Shalala, and other Agency leaders, on the unmet needs of Indian people. This bill certainly will provide the IHS with organizational independence and the capacity to advocate for itself at a higher level with more authority.

If S. 299, is enacted into law, Dr. Michael Trujillo would have greater influence in ensuring that other DHHS funding is available to meet the health needs of Indian communities.

On May 12, 1999, Tribal leaders from the Dakotas and Montana met with the President of the United States, William Jefferson Clinton. In their meeting they discussed nine topics, one of which included disparities in health care among American Indians and Alaska Natives. They reminded the President of his Executive Order dated May 14, 1998, and his Policy Statement issued on April 29, 1994, on Government-to-Government relationships between the United States and Tribal Governments. In the presence of Dr. Trujillo and Deputy Secretary Kevin L. Thurm, they noted the necessity of allowing Tribal Governments to move forward on these policies by eliminating the levels of bureaucracy within the DHHS by elevating Dr. Trujillo to the position of Assistant Secretary for Indian Health.

S.406, the Alaska Native and American Indian Direct Reimbursement Act of 1999

It is our understanding that S. 406, amends the Indian Health Care Improvement Act to make permanent the demonstration program under which Indian tribes, tribal organizations, and Alaska Native health organizations that contract or compact for the operation of a hospital or clinic of the Indian Health Service may directly bill for, and receive payment for, health care services provided by such hospital or clinic for which payment is made under Medicare or Medicaid or from any other third party payor. In addition to permanently authorizing this program, the National Indian Health Board understands that S. 406 would allow other tribes and tribal organizations, including those operating under Indian Self-Determination Contracts or Self-Governance compacts, to participate in the direct billing program and receive payment for services provided in their hospitals and clinics for Medicare, Medicaid and other third party payors.

Because of the federal trust responsibility and the government-to-government relationship between tribes and the federal government, many tribes would prefer to deal with a federal agency directly rather than going through their state governments for Medicaid and Medicare payments. This makes sense since the 100 percent federal match, under the IHS/Health Care Financing Administration Memorandum of Agreement, makes Medicaid a federally funded program for

American Indians and Alaska Natives. Furthermore, there is a precedent in the Medicare program. Currently when providers bill Medicare, they send the billings to the federal government through a fiscal intermediary.

When Congress authorized the demonstration project for "direct billing of Medicaid," it raised tribal expectations that the demonstration would develop a mechanism to bypass state government. Instead the demonstration project bypasses the Indian Health Service so that tribes and tribal organizations can receive Medicaid payments directly from the state. We have long recognized the success of the Bristol Bay Health Corporation, the Southeast Alaska Regional Health Corporation, the Mississippi Band of Choctaw and the Choctaw Tribe of Oklahoma in their demonstration of direct billing. It has been our desire to secure funding from private philanthropic foundations to evaluate the demonstration project and the tribes ability to increase collections and decrease turnaround time between billing and payment. We have long understood that by expediting direct reimbursement, the tribes have also been able to improve their JCAHO Accreditation ratings and the quality, as well as the level, of health care available to their patients.

In 1998, the National Indian Health Board completed a nine state study on best practices in Medicaid and Managed Care. We have found that as Indian health facilities and programs are becoming increasingly dependent upon Medicaid funding, they are affected by the current trend by states to provide Medicaid services through managed care plans. Our study conducted in the states of Arizona, California, Michigan, Minnesota, New Mexico, New York, Oklahoma, Oregon and Washington provided us with an opportunity to understand how Managed Care approaches are affecting Indian health and assess which provisions work best for American Indian and Alaska Native consumers and Indian health providers. While the scope of the study focused on Medicaid, we believe there are similar concerns within Medicare which will be the subject of study later this fall.

We understand from our studies of Medicaid and Managed Care, that the demonstration project has been successful and there is demand to increase the number of tribes and tribal organizations that can receive payments in this way, so that they can improve their cash flow and reconcile payments with their billings promptly. For purposes of today's hearing, I am happy to make available a copy of the Executive Summary which recommends in it's findings that, "Congress should reauthorize the current demonstration project for 'direct billing of Medicaid' and expand it to allow more tribes to participate."

As you are well aware, this past week, more than 450 representatives of Tribal Governments, the Indian Health Service and urban Indian programs participated in a national forum on the reauthorization of the Indian Health Care Improvement Act which is due to expire on September 30,

2000. We have undertaken an unprecedented step to provide the key authorizing Committees in Congress with a consensus bill drafted by the Tribes for your consideration during the remainder of the 106th Congress. Numerous comments were made about the draft bill and we are expecting final recommendations to be integrated into the bill for your introduction when the Senate re-convenes after the August recess.

Title IV of the draft reauthorization bill provides a variety of changes to the Indian health provisions within the Medicaid, Medicare and State Child Health Insurance Programs, which serve to strengthen the capacity of tribes and tribal organizations to improve their reimbursements. While we have not recommended specific changes to the bill language contained within S. 406, we respectfully request that the Committee consider adoption of the draft provisions recommended within Title IV of the new Indian Health Care Improvement Act reauthorization bill. This particular Title is now undergoing review by the Health Care Financing Administration and the Indian Health Service, who will provide technical assistance to the National Steering Committee on Reauthorization on changes that might improve the bill. These changes will be considered by the Tribes and recommended for integration into the draft reauthorization bill prior to its September introduction.

Conclusion

On behalf of the National Indian Health Board, I thank the Committee for considering our testimony on S. 299 and S. 406. We have supplied the Committee with resolutions which indicate our unequivocal support of previous measures similar to S. 299. On July 22, 1999, we joined in support and recommended that the National Congress of American Indians (NCAI) pass a new resolution in support the elevation of the Director of the Indian Health Service to Assistant Secretary for Indian Health. I believe my colleague, NCAI President W. Ron Allen will present this resolution which indicates our support.

Our views on S. 406, a bill to make permanent and expand the ability of Tribes to seek direct reimbursement of Medicaid and Medicare from the Federal Government, are shaped by our studies on Medicaid and Managed Care. We believe the demonstration project has enhanced the capacity of the four Tribes who participated in the project to increase their revenues and improve the quality of health care within their communities. The capacity to improve Medicaid and Medicare reimbursements in all Tribal communities is a worthy goal and will certainly lead to improvements in the quality of care.

Indian Health in Nine State Medicaid Managed Care Programs

Mim Dixon

September 30, 1998

Part 1. Executive Summary:

Medicaid Managed Care Issues and Recommendations

Principles for the Development of Medicaid Managed Care Provisions Related to Native American Consumers and Indian Health Providers

As states develop their Medicaid managed care programs and as the Health Care Financing Administration (HCFA) exercises its federal trust responsibility with regard to federally-recognized tribes in the approval process for Medicaid state plans and waivers, the following principles should guide decisions:

1 . In recognition of the inherent sovereignty of Indian tribes and nations, the requirements and goals set forth by Congress in the Indian Health Care Improvement Act (P.L. 94-437) and the Indian Self-Determination and Education Assistance Act (P.L. 93-638), and the special status and programs for American Indians in federal law, states should consult with tribes in the development of their health programs and make special provisions for American Indian and Alaska Native consumers and Indian health system providers in Medicaid and other health programs that receive federal funding.

2. Because there are cultural, geographic, financial and historic barriers to accessing health care, special health care delivery systems have been developed for American Indians and Alaska Natives. States should design their Medicaid and other programs to protect and enhance

Indian health facilities and services so that they can provide the highest possible level of care to people both when they are Medicaid beneficiaries and when they are not receiving Medicaid.

3. American Indian and Alaska Native individuals who are Medicaid beneficiaries should have access to their customary Indian health providers, as well as providers that are available to other Medicaid beneficiaries.

4. The Indian health facilities should be paid by Medicaid for every visit in which Medicaid-covered services are provided to a Medicaid beneficiary. This applies to the Indian Health Service (IHS) direct service facilities, tribally-operated facilities, and urban Indian clinics, collectively known as the I/T/U.

5. The I/T/U should be paid by Medicaid at a rate that covers the cost of delivering services, considering that there is little opportunity to shift costs to other third party payers.

6. Barriers to participation should be eliminated for American Indians and Alaska Natives for health care programs that receive any federal funding.

7. Recognizing the limitations in funding, resources should be used to the maximum extent for direct patient care and prevention activities while keeping administrative functions as efficient as possible,

Issue 1. Balanced Budget Act Protections

Summary of Issue: When Congress passed the Balanced Budget Act of 1997 (BBA), they recognized the need to protect American Indians from mandatory enrollment in managed care. Language was included in that Act that gives states the opportunity to include in their state plans mandatory enrollment in managed care plans; however, states can only require Native Americans in Medicaid to receive services through a Managed Care Organization (MCO) or Primary Care Case Management (PCCM) if the MCO or PCCM is the [HS, a tribally operated program or an urban Indian health program. Most states that have managed care Medicaid programs have used the waiver process. Until HCFA publishes the regulations related to the BBA, states in this study

are taking a wait-and-see approach regarding whether to continue to use the waiver process or to include mandatory managed care in their state plans. Using the waiver process with approval from HCFA, some states are requiring American Indians to enroll in Medicaid managed care plans.

Recommendation: The same protections that Congress provided for American Indians in the BBA should be provided under state waivers that limit freedom of choice. Federal law should be amended to prohibit HCFA from granting waivers that include mandatory enrollment in managed care plans unless those waivers exempt American Indians and Alaska Natives from mandatory enrollment in plans that are not operated by the I/T/U.

Issue 2. IHS/HCFA MOA

Summary of Issue: The IHS/HCFA MOA is an important agreement. However, states are not signers on this agreement. Various states and HCFA regional offices have interpreted it differently. Some areas that need clarification are the definition of an encounter, the number of encounters per day, the situations in which the 1 00 percent Federal Medical Assistance Percentage (FMAP) applies, and the state role in assuring that licensing standards are met.

Recommendations:

1 . The provisions for 100 percent FMAP and the IHS encounter rate for tribally operated facilities should be specified in law.
2. Regulations should be developed by a joint tribal-federal rulemaking committee that includes HCFA and IHS, using the negotiated rulemaking model that was used for P.L. 93-638. This process should be used to address the following:
    a. The formula used to develop the encounter rate.
    b. The definition of an encounter and the types of services to which the encounter rate is applied.
    c. The situations in which more than one encounter can be billed for an individual on the same day, recognizing that access barriers are reduced, including transportation and child care, when a patient can receive different types of visits on the same day.
    d. Situations in which the 1 00 percent Federal Medical Assistance Percentage (FMAP) applies.
    e. The state role in assuring that licensing standards are met.

3. The IHS/HCFA MOA should be expanded to include urban Indian clinics.

Issue 3. I/T/U Billing for Medicaid

Summary of Issue: Managed care has created complicated billing practices that have increased the need for office staff in I/T/U facilities and this has diverted resources from direct patient care. Under Medicaid managed care, virtually all IHS and tribally operated facilities are paid on a fee-for-service or encounter rate basis. Capitation is generally not feasible due to several factors including the federal Anti-Deficiency Act; some I/T/U clinics are small and serve a low number of patients, they lack other third party payers to absorb cost-shifting, and the population has a high need for health services and relatively few healthy people to absorb the risk. The OMB rate is higher than the Medicaid fee for service rates for outpatient visits in all states and this necessitates complex billing practices when Indian health providers are required to bill health plans.

Recommendations:

1 . A fee for service option, that includes the IHS encounter rate or FQHC rate, should be retained in all state Medicaid programs and available to American Indian and Alaska Native consumers and Indian health providers.
2. Indian health providers should receive payment for services to IHS beneficiaries who are also Medicaid recipients from states or their fiscal intermediaries directly and not be required to bill health plans.
3. States should intervene to assist I/T/U providers in collecting outstanding Medicaid payments from health plans.

Issue 4. Payment for Off-Plan Services

Summary of Issue: When American Indians and Alaska Natives enroll in health plans, either by choice or through mandatory enrollment, they may still seek services from I/T/U providers that are not in the plan's network and they will not be turned away. However, some state Medicaid programs do not have provisions for paying for these off -plan services. The Indian Health Care Improvement Act creates a legal basis for the IHS and tribes to collect from both Medicaid and commercial plans for off -plan services they provide.

Recommendation: HCFA should require all state Medicaid managed care programs or Medicaid managed care contractors to have provisions to pay the I/T/U for off-plan services

provided to IHS beneficiaries who are also Medicaid beneficiaries at rates specified by the IHS/HCFA MOA.

Issue 5: FQHC Rates

Summary of Issue: In the Balanced Budget Act of 1997 (BBA), the Federally Qualified Health Center (FQHC) rate is scheduled to be reduced each year and eliminated by the year 2003. While tribally-operated clinics can use the IHS rate for American Indian Medicaid consumers, they may not be able to use this rate for non-Indians and the FQHC rate is a better alternative than the Medicaid fee-for-service rates. Most urban Indian clinics do not have access to the OMB rate. The FQHC rate provides reasonable cost reimbursement which is necessary since Indian health providers do not have sufficient third party resource to absorb costs shifting and the population seeking care is generally sicker than the population as a whole. While the payment process under FQHC is based on cost reporting that is clear and defensible, it can take years to receive payment and it is costly to administer for tribes that do not receive Medicare reimbursement.

Recommendations:

1. Congress should develop an alternative to the current process for FQHC reimbursement that provides an enhanced rate to assure the viability of Indian health providers. The following options should be considered:
   a) Expand the IHS/HCFA MOA to include urban Indian clinics and nonIndians served in I/T/U facilities.
   b) Create another methodology that provides reasonable cost reimbursement that is tied to measurable information.
2. In waivered states, the full cost reimbursement for FQHCs should be maintained at the 1 00 percent level until at least the year 2003.

Issue 6: Increasing Native American Participation in Medicaid, Child Health Insurance Programs (CHIP) and Other Health Programs Receiving Federal Funding by Eliminating Cost Sharing and Other Barriers

Summary of Issue: Consumer cost sharing creates a barrier to participation by eligible American Indians. Because Indian health services are free of charge to the consumer, and eligible Native Americans cannot be turned away, there is little incentive for IHS beneficiaries to pay the consumer cost sharing to enroll in expanded Medicaid programs,CHIPandotherfederally-

fundedprograms. Consumercostsharingnotonly reduces participation by Native Americans, but also reduces revenues for Indian health facilities.

Other barriers to participation in Medicaid, CHIP and other health programs include lengthy application forms, the requirement for a face-to-face interview at an off ice that is diff icult to access and producing documentation related to income. These barriers can be reduced by providing eligibility workers at I/T/U facilities and making the applications more user-friendly.

Furthermore, in states that have not used CHIP to expand Medicaid, but rather developed a separate program that contracts with managed care plans, there are barriers to the I/T/U becoming providers under those plans and they generally do not pay for off -plan services. The result is that American Indian consumers and I/T/U providers do not benefit from these federally-funded CHIP programs.

While QMB and SLIMB are two Medicaid programs designed to increase access to Medicare Part B, there is little participation by American Indians. More needs to be done to remove barriers, inform American Indian and Alaska Native consumers and providers about these programs and to assist them in the enrollment process.

Recommendations:

1. The federal government should mandate that states waive consumer cost sharing for American Indians and Alaska Natives in Medicaid programs, CHIP and other programs with federal funding.
2. The federal government should mandate that state Medicaid and CHIP managed care programs pay for services to Al/AN enrolled in managed care plans who go off -plan to receive services from I/T/U providers.
3. State Medicaid programs should provide eligibility workers in I/T/U facilities and Indian schools, and find other ways to make the application process more user-friendly.
4. HCFA and the states should provide resources for appropriate training and outreach on QMB and SLIMB to Indian health providers and consumers, and various subdivisions of state government.
5. The federal government should provide an Indian set aside for the Child Health Insurance Programs.
6. The IHS/HCFA MOA should be expanded to assure that states receive the 1 00 percent Federal Medical Assistance Percentage (FMAP) for the State Child Health Insurance Program services to American Indians and Alaska Natives.
7. States that have already expanded their Medicaid to the extent provided by the Child Health Insurance Program should be allowed to submit 11 15 waivers to cover the remaining uninsured children and use the federal allocation for CHIP to accomplish this goal.

Issue 7. Medicaid Waiver Renewals

Summary of Issue: HCFA grants 1915(b) waivers for a two year period, while 11 15 waivers are for a period of five years and subject to extension. Prior to the renewal of waivers, an independent assessment is done to determine the affect of waivers on Medicaid populations. Currently, HCFA does not explicitly require these assessment to address American Indian consumers and providers, nor do they require tribal consultation. Many I/T/U providers are concerned that special provisions for Native American consumers and Indian health providers will be eliminated in the waiver renewal process. At the same time, the waiver renewal process provides an opportunity for states to assess their policies and procedures with regard to Indian health and to make any needed improvements.

Recommendation: In addition to requiring tribal consultation in the 1915(b) and 1 1 15 waiver application, HCFA should institute procedures for tribal consultation in the renewal assessment process and renewal application review for 1915(b) and 1 1 15 waivers.

Issue 8. Access to Medical Specialists Under Medicaid Fee for Service Options

Summary of Issue. As an incentive for everyone to participate in managed care programs, state Medicaid programs have kept their fee for service rates paid to medical specialists so low that it creates access problems in some places for American Indians who opt to remain in a fee for service Medicaid program.

Recommendation: HCFA should enforce its current regulations regarding accessibility by reviewing state Medicaid rates under both fee for service and managed care to assure that American Indians access to necessary specialty medical care is not being restricted.

Issue 9. Allowing Tribes to Bill the Federal Government for Medicaid

Summary of Issue. Because of the federal trust responsibility and the govemment-togovernment relationship between tribes and the federal government, many tribes would prefer to deal with a federal agency directly rather than going through their state governments for Medicaid payments. This makes sense since the 100 percent federal match makes Medicaid a federally funding program for American Indians and Alaska Natives. Furthermore, there is a precedent in the Medicare program. Currently when providers bill Medicare, they send the billings to the federal government through a fiscal intermediary. When Congress created a demonstration project for "direct billing of Medicaid," it raised tribal expectations that the demonstration would develop a mechanism

to bypass state government. Instead the demonstration project bypasses IHS so that tribes and tribal organizations can receive Medicaid payments directly from the state. The demonstration processes has been successful and there is a demand to increase the number of tribes and tribal organizations that can receive payments in this way, so that they can improve their cash flow and reconcile payments with their billings. Many tribes would like to see a demonstration project for billing HCFA or its fiscal intermediary directly for Medicaid covered services, without going through either the IHS or state governments.

Recommendations:

1. Congress should reauthorize the current demonstration project for "direct billing of Medicaid" and expand it to allow more tribes to participate.
2. HCFAshouldapprovearesearchanddemonstrationprojectfortribestobill HCFA or its fiscal intermediary directly for Medicaid without going through IHS or state governments, similar to the billing process for Medicare.

Issue 10. Monitoring the Effects of Managed Care Medicaid Programs on American Indian and Alaska Native Consumers and Indian Health Providers

Summary of Issue. This project has identified a number of issues that affect American Indian and Alaska Native Medicaid beneficiaries and Indian health providers. These issues require further evaluation and monitoring efforts on a national basis.

Recommendations: Congress should provide an annual appropriation of new funding, not to be subtracted from current IHS appropriations, for evaluation of Medicaid Managed Care and Indian Health to include the following oversight activities:

1 . A Medicaid Managed Care and Indian Health Monitoring Committee should be formed with participation from tribes, urban Indian programs, the Indian Health Service, the Health Care Financing Administration, and states, to prioritize evaluation and monitoring needs and provide oversight for on-going studies.
2. An annual meeting should be held for researchers to share their findings about managed care and Indian health.
3. A newsletter should communicate findings to Indian health providers and state and federal agencies involved with Medicaid and managed care.

4. The Medicaid Managed Care and Indian Health Monitoring Committee should provide a annual report to Congress on the impact of Medicaid managed care on Indian health facilities and access to care for IHS beneficiaries.